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Illinois Department of Public Aid

MEDICAL ASSISTANCE PROGRAM

The Medical Assistance Program provides for payment of allowable medical care received by 1) public aid grant recipients, and 2) certain other individuals and families who do not need assistance to meet their general living costs but who do require help in meeting the cost of medical bills.
The program, financed jointly by the State of Illinois and the federal government, is administered by the Illinois Department of Public Aid through its local offices in the state's 102 counties.

WHERE TO APPLY

Persons receiving Aid to Families with Dependent Children (AFDC) are eligible for medical services; consequently they are not required to apply for Medical Assistance. Aged, blind, or disabled persons who are receiving state supplementation to federal Supplemental Security Income (SSI) payments are also eligible for Medical Assistance and are not required to apply.
Other individuals or families who need assistance to meet the cost of current medical care may make application for Medical Assistance at the public aid office in the county of residence. If need for medical assistance occurs while hospitalized, application for this assistance may be made while in the hospital. If the person asking for assistance is unable to complete the application, it may be made in behalf of the applicant by a relative or other person who has sufficient knowledge of the applicant's circumstances to furnish information.

INFORMATION TO APPLICANTS FOR MEDICAL ASSISTANCE

1) **How Soon Should You Find Out if Your Medical Assistance Application Was Approved? What Are the Time Limits?**
   Within 45 days of the date you applied, unless you are applying on the basis of disability, in which case the decision must be made within 60 days.
2) **What if the Department Doesn't Decide if You Are Eligible For Medical Assistance Within These Time Limits?**

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If the Department makes a decision on your application after these time limits, the Department may have to pay you back for bills you paid after the time limits because of the Department's delay. Save copies of any bills paid after these time limits. The Department will send you a letter if you are eligible for being paid back under this provision.

3) **What Do You Get if Your Application is Approved?**
If your application is approved, the Department will pay bills for services it covers for all the time you are eligible. This can include up to three months prior to the month in which you apply and the time you are awaiting a decision after you apply. You should, if possible, not pay your medical bills until you learn if you are eligible for medical assistance so that the Department can pay them.

4) **What Happens if You Have Income Greater Than the Medical Assistance Standard?**
If you are determined eligible but your income is more than the standard for the established period, you will be enrolled in the Medical Assistance Program. Before you can get a medical card you must incur medical expenses equal to the amount of income over the standard. This is referred to as your Spend-down obligation. Once you provide the Department with proof that you incurred the proper amount of medical expenses, the Department will provide medical assistance for the remainder of your established period.

SERVICES AVAILABLE

Medical Services. The Medical Assistance Program is designed to provide essential medical services required by the applicant's condition due to illness, infirmity, or disability when such medical care is recommended by a qualified practitioner, and when the necessary care is not available to the individual from any other source.

The medical services and supplies for which payment can be provided are: in-patient and out-patient hospital services; clinic care; physical rehabilitation services; laboratory and x-ray

services; family planning services; nursing care in the home; skilled nursing facility care; home health care services; special duty nursing care for a hospital patient; care in intermediate care facilities; physicians' services in the office, patient's home, hospital, nursing home, or other appropriate place; psychiatric services; early and periodic screening for diagnosis and treatment of children (Medichek); dental care; eye care; podiatry services; chiropractic services; physical therapy occupational therapy, speech therapy, and audiology provided by or supervised by a qualified therapist; drugs, medical supplies, sickroom needs, appliances and prosthetic devices; second opinions regarding the need for surgery. Service coverage for adult AFDC clients eligible for Medical Assistance only does not include all of the above items. Your caseworker will supply you with specific information on service limitations.

Funeral and Burial Expenses. Funeral and burial expenses are allowable for otherwise self-supporting persons who are receiving services under the Medical Assistance Program in accordance with the Department's payment standards when 1) the deceased was eligible for medical services at the time of death, 2) the estate is insufficient to pay the cost of funeral and burial, and 3) no legally responsible relatives are able to pay the costs.

Food Stamps. Persons and families receiving Medical Assistance may also be eligible for food stamps. They should consult the local public aid office.

Social Services. Applicants and recipients of Medical Assistance are eligible for information, referral and follow-up services, for help with plans when alternate care arrangements are needed when leaving a state hospital; and for a range of social services provided by other state agencies.

ELIGIBILITY FOR MEDICAL ASSISTANCE

Persons who have sufficient income to cover their general living expenses but who need assistance to pay their medical expenses will qualify for Medical Assistance if they meet all of the following eligibility requirements:

Financial Eligibility. Individuals or families are eligible for Medical Assistance when the amount of their non-exempt income is less than the income standard for the established period. Individuals or families having income greater than the standard must incur medical expenses equal to the amount of the excess income before the Department will provide medical assistance for the remainder of the established period.

In determining an applicant's or recipient's eligibility for Medical Assistance, the following income is considered available: 1) non-exempt income available over a six-month period (one month period for group care) in excess of the Department's standards, and 2) available contributions from responsible relatives. Third party resources such as Medicare or health insurance must be reported. Persons legally responsible for support of needy relatives are spouse for spouse and parents for the support of children under age 21; except that a parent is not responsible for a child age 18 or over if it can be determined that the child has in fact established a consistent pattern of independent living arrangement prior to the child's application for assistance.

Earned and Unearned Income. Income available to the applicant or recipient will be considered for the six-month period (one month period for group care) for which the person's eligibility is being determined for medical assistance. The established period of eligibility determined for each applicant begins with the month of application provided the applicant meets all eligibility requirements; or the period may begin up to three months prior to application if necessary. The beginning medical eligibility date within the established period will be either the first day of the first month of the period or the day on which the Spend-down obligation is met. A portion of income may be exempt from consideration in determining eligibility for medical Assistance in accordance with income exemption policies. Six months (one month for group care) non-exempt income in excess of the medical assistance standard is the Spend-down obligation. For Group Care cases, the excess non-exempt income is payable directly to the facility.

Assets. Assets exempt from consideration in determining the eligibility of applicants for Medical Assistance are: homestead property, clothing and

personal effects, and household furnishings. Also exempt is the equity value of non-homestead property, stocks, bonds, savings accounts, and cash, provided the total value of any or all the items does not exceed $1500 for one person, or $2250 for a client living with the dependent, and $50 for each additional dependent family member. If the value of assets exceeds these amounts, the individual or family is not eligible. For persons whose medical eligibility is based on being aged, blind, or disabled, exempt assets also include business or farming equipment essential to produce income, motor vehicle(s), certain group life insurance if the face or cash value does not exceed $1000 per eligible family member. A prepaid burial plan may be exempt. For persons whose medical eligibility is based on being deprived in whole or in part of parental support or care exempt assets also include one automobile if the equity value is not greater than $1500.

Summary of Financial Eligibility. An applicant's or recipient's non-exempt income (including contributions from responsible relatives) over an established six-month (one month period for group care) is considered in the determination of financial eligibility for Medical Assistance. A person or family having non-exempt income in excess of the income standards will be enrolled in the Medical Assistance Program but must incur medical expenses equalling the excess income before a medical card will be issued for the remainder of the established period. For Spend-down cases in the community, Medical Assistance automatically stops at the end of the established six month period. For additional medical assistance, a new application is required.

Residence. Applicants for the Medical Assistance Program must be residents of Illinois and must be citizens of the U.S. or have legal alien status. Temporary absence from the state does not disqualify an applicant if all other eligibility requirements are met.

Other Eligibility Factors. With the exception of the financial eligibility requirements, WIN Demonstration Project and Job Service registration requirements, and school attendance requirements for persons over age 18, all other eligibility factors are the same as those in effect for AFDC. Families may be eligible for the Medical Assistance Program if:

1) There are one or more children under the age of 21 in the family group;
2) The children are deprived of parental support or care by the death, physical or mental incapacity, full or partial unemployment or continued absence for such reasons as unmarried parenthood, divorce, separation, imprisonment, or military service of either parent; and
3) The children are living with an adult who is their parent or other close relative such as an adoptive father or mother, grandmother, grandfather, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle or aunt.

Pregnant women with no children may receive Medicaid if all other eligibility factors are met. A person without young children at home may be eligible for Medical Assistance, if the person is: 65 years of age or over; or blind to the extent that even with glasses he is unable to perform ordinary duties; or disabled—either physically or mentally—to the extent that he/she is unable to work at an occupation for which he/she is suited.

If the person applying for Medical Assistance is receiving cash assistance from the federal program of Supplemental Security Income (SSI) or applied for and is approved to receive SSI, this will be accepted as evidence that the person is either aged, blind, or disabled. If the person applying does not receive SSI and does not wish to apply for SSI, then that person's age, blindness, disability or incapacity must be established by the Department of Public Aid—including medical examination as appropriate.

Public Institutions. Depending upon the type of care they are receiving, needy persons who reside in facilities operated by the Department of Mental Health and Developmental Disabilities may be eligible for Medical Assistance. Needy Persons age 65 and over who are residing in public tuberculosis hospitals may be eligible for Medical Assistance. Generally inmates of penal or correctional institutions are ineligible. In certain instances, inmate's medical costs may be paid by the Department. Persons about to be released from an institution may apply for Medical Assistance for services needed after release.

Persons discharged from a mental health facility solely for the purpose of receiving medical care in a general hospital, and who then return to the mental health facility may be eligible for Medical Assistance while in the general hospital.

Transfer of Property. An aged, blind or disabled person who has transferred either real or personal property for inadequate consideration within two years of the date of application for Medical Assistance is ineligible for assistance if the transfer was made for the purpose of qualifying for or increasing the need for assistance. The person is ineligible for up to two years from the date of the transfer, or for as long as the transferred property would meet the person's needs, whichever comes first.

Determination of Eligibility. Applicants for Medical Assistance will be expected to provide information needed to determine their eligibility. The applicant will be notified of the decision within 45 days of the date of application (60 days if eligibility is based on disability).

For cases not required to meet a Spend-down obligation, a redetermination of eligibility is made at least once every 12 months or sooner if changes occur.

PAYMENT PROVISIONS

The Department will make payments to persons or institutions enrolled to participate in the Medical Assistance Program for covered medical services provided through the Program. Resources such as medical, surgical, or health insurance are considered prior to payment. Payments will cover only the allowable medical expenses which the eligible individual incurs after meeting spend-down requirements computed in accordance with Department standards and after co-payment obligations are deducted.

RIGHTS OF APPLICANTS AND RECIPIENTS

Right to Apply. Any persons who believe they may be eligible for medical services have the right to apply under the Medical Assistance Program.

Choice of Vendors. Persons receiving Medical Assistance are entitled to a free choice of doctors, hospitals, or other providers of medical services which meet the requirments of and comply with the rules and regulations of the Department. Recipients who are found to be overusers of medical services will be required to designate one physician who will be responsible for providing or authorizing non-emergency medical care.

Advance Notice. Persons receiving Medical Assistance will be given 10 days advance notice in writing before a local office acts to reduce, suspend, or cancel their assistance. They will also be given the opportunity for an informal conference with a local office representative to discuss the reasons for the proposed change. This is not the same as an appeal, nor does it prevent a recipient from appealing after such a conference.

Right of Appeal. An applicant or recipient may make an appeal in writing to the local public aid office or to the Illinois Department of Public Aid within 60 days. The local office will provide a form which the applicant may use in making the appeal. Legal fees are not paid by the Department. If the recipient is appealing a proposed reduction, or termination of assistance and the appeal is filed within the 10-day advance notice period, the assistance may be continued during the hearing process. Assistance is not continued past the expiration of the six-month established period for a spend-down client. The hearing conducted by a state hearing officer is without cost to the appellant and is held in the county of residence.

At the hearing the appellant will have the opportunity to present the case or have it presented by legal counsel or someone acting in a representative capacity, to introduce evidence and witnesses in the appellant's behalf, and to examine before and during the hearing any material the local office plans to introduce as evidence.

Unless the appellant has requested a delay in the

hearing process, the Department will notify the appellant by letter of its decision on the appeal and implement the appeal decision within 90 days after the appeal is filed. For complete details, see brochure DPA 377, *The Right to Appeal and to Receive a Fair Hearing.*

Civil Rights. The Illinois Department of Public Aid administers all programs under its jurisdiction in conformance with Title VI of the Civil Rights Act of 1964, and United States Department of Health and Human Services regulations defining state responsibilities under that Act.

Therefore, the Department of Public Aid does not, directly or through contractual or other arrangements, on the ground of race, color, sex, national origin, or handicap, deny any individual aid, care, services, or other benefits provided under the programs; differentiate in the kind of aid, care, services, or other benefits provided, or in the manner in which they are provided, subject an individual to segregation or separate treatment in any manner related to receipt of aid, care, services or other benefits; restrict any person from having the same advantages and privileges of all others in receiving them; treat an individual differently than others in determining eligibility or other requirements to qualify for aid, care, services, or other benefits; deny or offer any person an opportunity different from that offered others. Persons wishing to complain of alleged discriminatory conditions or practices by the Department of Public Aid, or other agencies, institutions, organizations, or individuals, may state their complaint at the local public aid offfice. The complaint may be sent to the local office or to the Illinois Department of Public Aid, Supervisor of Inquiries, 316 South Second Street, Springfield, Illinois 62762, or to the Secretary, U.S. Department of Health and Human Services, 330 Independence Avenue, S.W., Washington, D.C. 20201.

The Department of Public Aid will investigate all complaints and take corrective action when indicated by the findings. The Director of the Department will review the action taken, and the complainant will be informed in writing of the disposition of the complaint. Decisions may be appealed.

For complete details, see brochure DPA 592, *Public Aid and Civil Rights.*

Protection of Personal Information. By law the contents of Department records pertaining to applicants and recipients may not be disclosed without client consent except for the purpose of administering the program.

RESPONSIBILITIES OF APPLICANTS AND RECIPIENTS

Applicants and recipients must report accurately all income and resources and other facts which have a bearing on their eligibility for assistance. Third party resources such as health insurance or Medicare must be reported. Recipients must report immediately any change in circumstances which may affect their eligibility or the amount of their spend-down obligation. By law, penalties are provided for knowingly and willfully misrepresenting material facts, for fraudulently securing medical benefits and for the misuse of medical benefits.

Recipient Penalties Under Section 1909 of the Social Security Act. Any person who knowingly and willfully makes a false statement or misrepresents information, or fraudulently conceals or fails to disclose information or knowingly and willfully converts his/her medical benefits for the benefit of any other person is guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, for an individual who is otherwise eligible for assistance and convicted of a Medical Assistance offense, the Department may limit, restrict, or suspend that individual's eligibility for a period not to exceed one year.

ESTATE CLAIMS

Claims will be made against estates to recover the amount paid for medical services in behalf of recipients of the Medical Assistance Program if the recipient was 65 years of age or over at the time the Medical Assistance was received, but only after the death of the surviving spouse and only when there is no surviving child who is under 21 or who is blind or permanently and totally disabled.

THE DEPARTMENT'S RIGHT

Sometimes the Department pays a medical bill when a third party resource such as Medicare or health insurance should have paid the bill. When this happens, the Department of Public Aid has the right, by law, to get the money from the third party resource. The Department of Public Aid does not need the client's consent to get this payment.

The Illinois Department of Public Aid does not discriminate in admission to, or treatment or employment in programs or activities in compliance with the Illinois Human Rights Act, the Illinois Constitution, the U.S. Civil Rights Act, Section 504 of the Rehabilitation Act, as amended, and the U.S. Constitution.

Department of Public Aid, 316 South Second Street, Springfield, Illinois 62762

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